Mail to: **EDS**
P.O. Box 31188
Raleigh, NC 27622

STATE TO STATE AMBULANCE TRANSPORTATION ADDENDUM

A. **Patient Name** _____

Address _____

_____

B. **Attending Physician** _____

Name and Number _____

C. **Facility** _____
(Point of Pickup)

_____

D. **Facility** _____
(Destination)

_____

E. **Date of Service** _____

Letter (signed by attending physician), which includes

Medical diagnosis
Recipient's physical condition
Ambulance transportation justification

F. I verify that there are no resources other than Medicaid to pay for the transportation:

_____ _____
(Signature/Title) **(Date)**

G. County _____

Telephone Number _____

Contact Person _____